South East **LHIN**

Achieving better health

2008-2009 Annual Report

Ontario
Local Health Integration Network

TABLE OF CONTENTS 1

MESSAGE FROM OUR CHAIR AND CEO 3

MEMBERS OF THE BOARD 4

INTRODUCTION 5

MINISTRY/LHIN ACCOUNTABILITY AGREEMENT 6

WHAT IS AN MLAA? 7
MLAA PERFORMANCE INDICATORS 7
SOUTH EAST LHIN INTEGRATED HEALTH SERVICES PLAN 9
IMPLEMENTATION OF THE IHSP 9
COMMUNITY ENGAGEMENT ACTIVITIES 12
FRANCOPHONE INITIATIVES 13
ABORIGINAL INITIATIVES 13
INTEGRATION ACTIVITIES 13

LHIN INITIATIVES IN SUPPORT OF GOVERNMENT PRIORITIES 14

ER WAIT TIMES INITIATIVES 14
IMPROVING THE ALC SITUATION 15
EHEALTH INITIATIVES 16

ANALYSIS OF SOUTH EAST LHIN OPERATIONAL PERFORMANCE 17

AUDITORS' REPORT 18

STATEMENT OF FINANCIAL POSITION 19
STATEMENT OF FINANCIAL ACTIVITIES 20
STATEMENT OF CHANGES IN NET DEBT 21
STATEMENT OF CASH FLOWS 22
NOTES TO THE FINANCIAL STATEMENTS 22

CONTACT INFORMATION 23

Message from our Chair and CEO

Achieving better health – the theme of the 2008/09 Annual Report, paints a clear picture of where the South East LHIN aspires in its day-to-day planning, funding and health care system accountability work. As leaders of the regional health care system, we take personal responsibility for ensuring our residents have access to timely, quality health care services not only today but also into the future.

To be successful, we must all work together – patients, clients, residents, health service providers, communities and families. As taxpayers, we provide funding to operate the system. As health care funders, we must be accountable for how we spend that money to deliver high quality, efficient and effective care. As patients, we must do our part to use services wisely and to enjoy healthier lifestyles. Together, we can achieve better health in our region.

Over the past year, we have spent thousands of hours talking with people about health care – about what they like and what they would like to see changed; how various organizations or services could work together to improve the experience for people receiving care. We have also spoken to many people and organizations about how to better control the ever-increasing costs for providing health care. These can be very uncomfortable conversations – but they are extremely important ones. The work we are doing today involves addressing difficult situations head on. It is about transforming the way we provide health care in the South East. Health care has strong emotional roots – not only do we recognize that, but we know the tough discussions we have today are essential for success tomorrow.

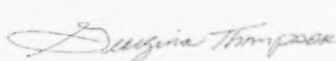
Our theme – *Achieving better health* – also anchors the Vision statement created by a group of residents selected at random from across the South East LHIN early in 2008. Given the LHIN is entrusted to plan and flow taxpayers' dollars for the provision of services, we wanted to ensure the vision of the region's health system represents the thoughts and ideas of its payers and users. These citizens made that happen.

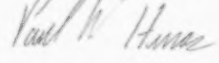
Our Vision

Achieving better health through proactive, integrated and responsive health care in partnership with an informed community

We encourage you to read this report, to visit our website and to become more engaged in the health care conversations we are having in the South East. Significant initiatives are underway in our LHIN through the dedicated efforts of the many talented individuals delivering and leading our health care services. A few key areas of focus include what we are doing about challenges we have in acute care hospitals due to the number of individuals who are awaiting discharge but cannot leave because they require other services that may not be readily available; how we are shortening waiting times in emergency rooms; and how we are working to ensure electronic access to health records and improving access to primary care.

A lot of work has taken place over the past year and the transformation of our health care system is well underway. We are confident that working together – system planners, providers, taxpayers and health care recipients – our vision will become our lived experience. Thank you for your ongoing support and interest. The health care system in the South East must provide all of us with safe high quality care within the resources available.





Georgina Thompson
Chair

Paul Huras
Chief Executive Officer

Members of the Board

Georgina *Tom* *Leslie* *John F* *John G* *Gaye* *Wynn* *Marg*

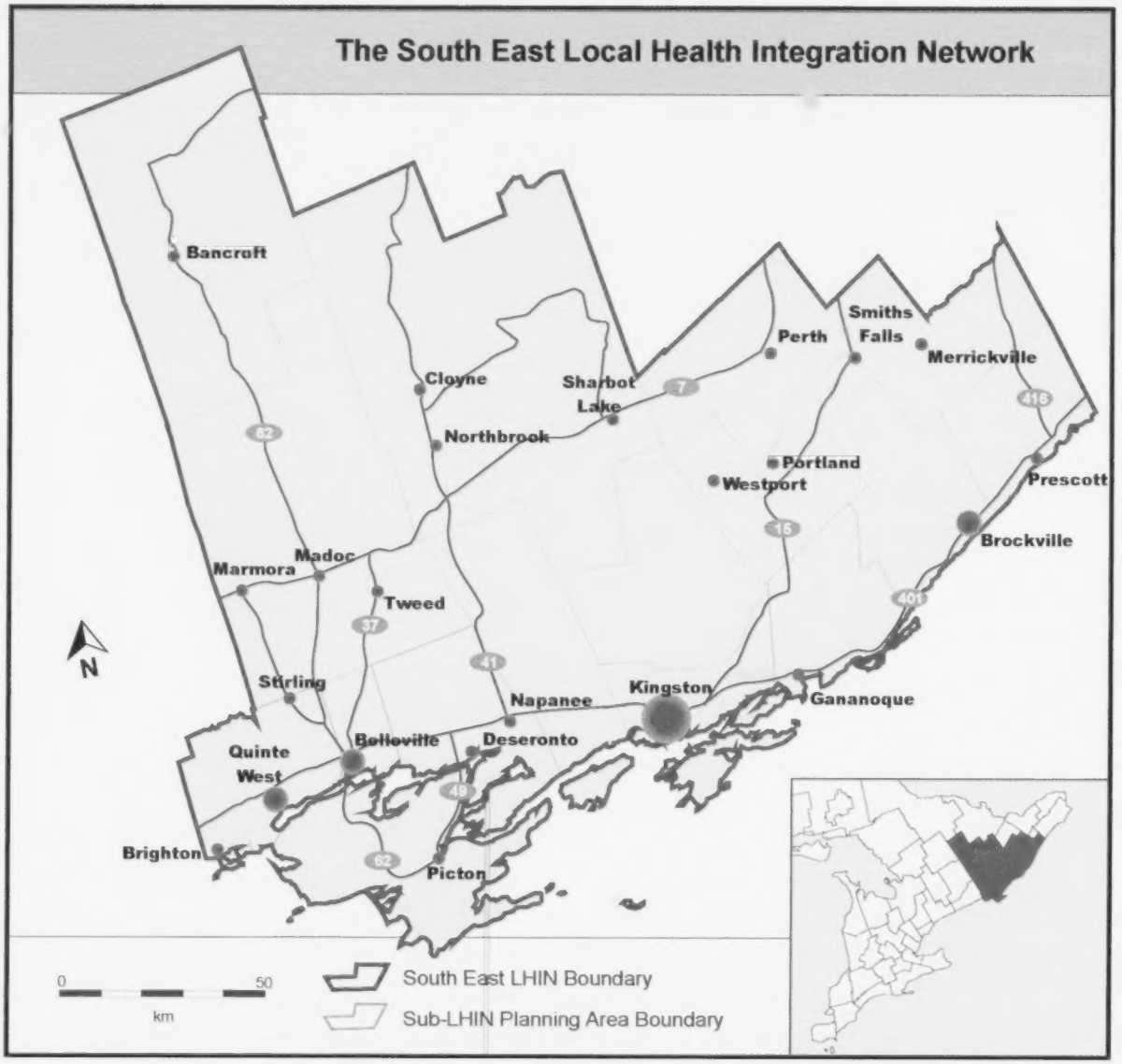
Georgina Thompson Chair	Term of Office: June 1, 2005 – May 31, 2008 Reappointed: June 9, 2008 – June 8, 2011
Thomas Rankin Vice Chair	Term of Office: May 17, 2006 – June 16, 2007 Reappointed: June 17, 2007 – June 16, 2010
Leslie Benecki	Term of Office: October 8, 2008 – July 10, 2011
John Ferguson	Term of Office: June 20, 2007 – June 19, 2008 Reappointed: June 20, 2008 – June 19, 2011
John Groves	Term of Office: January 5, 2006 – January 5, 2008 Reappointed: April 8, 2009 – April 7, 2010
Gaye McGinn	Term of Office: January 5, 2006 – February 4, 2007 Reappointed: January 24, 2007 – February 5, 2010
Wynn Turner	Term of Office: October 1, 2008 – November 30, 2009
Margaret Werkhoven	Term of Office: May 17, 2006 – June 16, 2007 Reappointed: June 17, 2007 – June 17, 2010
Kenneth Alan McBain	Term of Office: May 17, 2006 – May 16, 2008 Reappointed: May 17, 2008 Resigned: July 28, 2008

The governance structure for LHINs is set out in the *Local Health System Integration Act, 2006*. LHINs are Crown Agencies of the Province of Ontario and as such are governed by Boards of Directors appointed by the province.

Each LHIN has a maximum of nine Board members appointed by the Lieutenant-Governor-in-Council. Directors hold office for a term of up to three years and may be appointed for one additional term. The Lieutenant-Governor-in-Council is responsible for designating the Chair and at least one Vice-Chair from amongst the members.

The Board of Directors is responsible for the governance of the LHIN and is ultimately responsible to the Minister for the local health system. Details on the South East LHIN Board of Directors and its committees can be found on the South East LHIN web site at www.southeastlhin.on.ca .

Introduction



The South East LHIN is one of 14 Local Health Integration Networks established by the Government of Ontario as community-based organizations that plan, co-ordinate, integrate and fund health care services at the local level. Hospitals, long-term care homes, community care access centres, community support services, community mental health and addictions services and community health centres are all accountable to the LHIN.

The South East region is large – covering communities to the north and south of highway 401 from Brighton through to Cardinal, north to Perth and Bancroft, and south to Lake Ontario and the USA border. Our population, 486,000[1], is relatively small and spread across the region; with over 50% of the population located in urban centres along the 401 corridor. The remaining population is scattered across the LHIN in small rural communities.

About 85,000 of our residents are seniors. Demographic analysis indicates that this number is growing. The percentage of seniors will continue to be the highest in the province for the next decade.

Census Characteristics

	SELHIN	Ontario
No certificate, degree or diploma (age 25+)	20.0%	18.7%
Completed post-secondary education (age 25+)	53.4%	56.8%
Unemployment rate (age 15+)	6.2%	6.4%
Labour force participation rate (age 15+)	62.4%	67.1%
Proportion of population living in low income	11.9%	14.7%
English Mother tongue	91.5%	69.8%
French Mother tongue	2.7%	4.4%
Immigrants	9.3%	28.3%
Recent Immigrants (5 years)	0.8%	4.8%
Visible minorities	3.3%	22.8%
Aboriginal Identity	2.8%	2.0%

Population

	Population Counts		% of Total Population	
Year	SELHIN	Ontario	SELHIN	Ontario
		Total Population		
2006	482,078	12,705,344		
2009	486,101	13,050,754		
2011	492,452	13,349,125		
2016	510,626	14,149,965		
		Aged 65+		
2006	80,630	1,649,293	16.7%	13.0%
2009	86,097	1,770,571	17.7%	13.6%
2011	90,168	1,864,941	18.3%	14.0%
2016	105,224	2,214,279	20.6%	15.6%
		Aged 75+		
2006	37,269	781,257	7.7%	6.1%
2009	38,990	837,672	8.0%	6.4%
2011	40,324	871,594	8.2%	6.5%
2016	44,307	959,871	8.7%	6.8%
		Aged 85+		
2006	9,648	192,104	2.0%	1.5%
2009	10,718	228,156	2.2%	1.7%
2011	11,302	249,961	2.3%	1.9%
2016	12,494	294,008	2.4%	2.1%

[1] Population Projections, 2009. Ontario Ministry of Health and Long Term Care, Provincial Health Planning Database.

Ministry/LHIN Accountability Agreement

What is an MLAA?

The *Ministry-LHIN Accountability Agreement (MLAA)* clearly defines the relationship between the Ministry of Health and Long-Term Care (MOHLTC) and the South East LHIN in the delivery of local health care programs and services. It establishes a mutual understanding between the Ministry and the LHIN and outlines respective performance indicators within a pre-defined period of time.

MLAA performance indicators

MLAA Performance Indicator	LHIN 08/09 Starting Point	LHIN 08/09 Target	Most Recent Quarter 2008/09*	Annual Results**	LHIN Met Target YES/NO
90th percentile wait times for Cancer Surgery	63 days	58	58	63	YES
90th percentile wait times for Cardiac By-Pass Procedures	85 days	43	99	78	NO
90th percentile wait times for Cataract Surgery	135 days	135	104	117	YES
90th percentile wait times for Hip Replacement Surgery	282 days	227	147	187	YES
90th percentile wait times for Knee Replacement Surgery	369 days	300	144	222	YES
90th percentile wait times for Diagnostic MRI Scan	207 days	96	112	116	YES
90th percentile wait times for Diagnostic CT Scan	41 days	34	42	48	YES
Hospitalization Rate for Ambulatory Care Sensitive Conditions (Target rate / 100,000)	379	379	358	318	YES
Median Wait Time to Long-Term Care Home Placement – All Placements	126 days	123	180	142	YES
Percentage of Alternate Level of Care Days	17.1%	14.1%	18.64%	17.4%	NO
Rate of Emergency Department Visits that Could be Managed Elsewhere	54.9	54.4	61.8	51.2	YES
Readmission Rates for Acute Myocardial Infarction (target as %)	4.01%	3.80%	3.77%	3.93%	YES

Note: * Performance indicators 1-7 = Q4 2008/09; and 8-12 = Q3 2008/09
**Performance indicators 8-12 (in the Annual Results Column) only include the average of Q1-3

At the end of 2008/09, the South East LHIN was able to achieve the targets in all but two performance requirements identified in its MLAA. A description of these two targets and an explanation for the variance follows:

Performance Indicator # 2: 90th Percentile for Cardiac By-Pass Procedures

Since implementing changes to the new wait time database through the Wait Time Information System, issues with data entry at hospitals have been identified. Therefore the numbers may or may not reflect actual activity. To fix this, patients who are waiting for other tests prior to being ready for cardiac surgery are no longer able to be entered as pending in the system. This change has improved the quality of the local performance measures. Through discussion with Kingston General Hospital, the South East LHIN received updated forecasts for the projected number of cardiac procedures to be performed by March 31, 2009. Forecasts show a planned increase in activity to ensure higher patient volumes and to end increases in waiting times. This should reduce waiting times for cardiac bypass surgery in the first quarter of 2009-10.

Performance Indicator # 10: 90th Percentile of Alternate Level of Care (ALC) Days

Hospitals across the LHIN identified an increase in ALC patients and related pressure during the first half of 2008/09. In mid-September, the LHIN launched a targeted multiple-stakeholder initiative to aggressively tackle the systemic issues around alternate level of care. An ALC Strategic Working Group and associated implementation sub groups were brought together to identify longer term solutions to ALC pressures. The measures addressed by this group included examining the definition and designation of ALC patients, assessing the effectiveness and impact of Priority 1A designation and a communication strategy to highlight and combat a heightened propensity to designate frail elderly patients ALC. These actions initially reduced the number of ALC patients but numbers bounced back up by the end of the year.

Other issues related to ALC are outlined on page 12.

Service Accountability Agreements

LHINs are required to negotiate and monitor Service Accountability Agreements (SAA) with each of the health service providers that they fund.[2] These agreements set out service requirements and patient volumes as well as other performance objectives. LHINs work collaboratively with all their health service providers to ensure appropriate measures of contracted service requirements are established and used. To date, service accountability agreements form the basis of a multi-year funding and planning framework for the local health system. This creates greater funding stability for providers, enabling multi-year planning of services aligned to community need.

LHINs and hospitals signed their first hospital accountability agreements early in 2008. In March 2009, the first-ever service accountability agreements for community service providers (Community Health Centres, Community Care Access Centres, Mental Health and Addictions Agencies and Community Support Services) were signed.

Health service provider Boards of Directors have obligations under their SAA and provincial laws to establish and maintain broad and appropriate engagement of their communities when developing their own plans. This is particularly true if such plans contemplate changes to their service offerings. Providers are also obliged to identify and evaluate the potential benefits of integration opportunities within and among themselves. The intent is for providers to find better, faster, more effective and efficient ways to provide your health-care services. Service improvements could mean service expansion or could result in a provider reducing service where the need no longer warrants, or where another provider is better positioned to provide those services to the community.

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[2] Pursuant to Ontario Regulation 279/07 (3), Long-Term Care homes will sign accountability agreements with their respective LHINs by April 1, 2010.

South East LHIN Integrated Health Services Plan (IHSP)

In November 2006, the South East LHIN released its inaugural IHSP following detailed research and a significant number of conversations with health-care providers and the public at large. With a three-year horizon, the IHSP provides an initial perspective on the types of changes we need in our health care services. The IHSP includes the LHIN's vision, priorities and strategies for enhancing health care delivery through better integration of services between health care services and sectors.

The analysis of the health status of the South East population, our use of health services, the capacity and capability of our health service providers and the community engagement activities undertaken convinced planners in the South East that for the most part, the local health system is working well. However, several key priorities for change that allow the system to respond more expeditiously and comprehensively to the health service needs of the population were identified.

Priorities for change include:

- Access to
    i. Primary health care
    ii. Specialized medical care
    iii. Mental health services
    iv. Addiction services
    v. Rehabilitation services
    vi. Transportation to and from care

- Availability of long term care services (not just more long term care beds)
- Integration of services along the continuum of care making it easier for patients and health-care workers to move between services and organizations
- Engagement with Aboriginal communities
- Ensuring access to health care services in French
- Development of electronic health records
- Designing a regional health human resources plan

Implementation of the IHSP

Primary Health Care: The LHIN has worked closely with the Ministry in supporting and funding new Community Health Centre sites in Smiths Falls, Napanee, Belleville and Quinte West. These sites are designed to improve equity of access to primary health care services, support individuals in their efforts to assume greater responsibility for their own health and strengthen the role of the community in the delivery of health services. This is a coordinated primary health care service model that makes appropriate and efficient use of health care providers and health resources by taking a health management approach with patients; promoting healthy lifestyle choices to maintain health and prevent illness. In 2008/09 the sites in Smiths Falls and Napanee opened. Planning continues for the Belleville and Quinte West sites.

The LHIN is also proud to have played a role in the launch of Ontario's Health Care Connect patient registry in February. The registry helps match people with family physicians. The idea for such a registry was first discussed at a meeting in 2007 between LHIN representatives and Dr. Jeanette Dietrich of the Sydenham Medical Clinic and her colleagues from the family health organization that also provides care in Verona, Tamworth, Newburgh and Sharbot Lake. It is an idea that spread across the entire province.

LHIN CEO Paul Huras, Dr. Jonathan Kerr, Minister David Caplan, Dr. Jeanette Dietrich and Adrienne Harris-Hale visit the Health Options website.

Specialized Care: A working group of physicians and hospital representatives with specialization in surgical services is supporting implementation of the Regional Surgical Services program. A standardized electronic referral process is being launched through the Referral Quality Improvement Project. That means family physicians and surgical specialists will be able to access e-referral content, communication links and support information stored and managed on a secure central web-based server. Initially, access will be limited to 'regional surgical registered' family physicians and specialists from within the South East LHIN region. The appropriateness of referrals to specialists will be continuously monitored to determine if evaluation at a regional assessment centre is needed. The goal is to ensure the appropriate referral and patient management actions occur at the referral source (the family physician's office).

Work is also well underway to building a regional critical care system in the South East. Under the leadership of LHIN Critical Care Lead Dr. John Muscadere, the LHIN is looking at integration of its critical care units in the region and how they function as a network. At present, the South East has 102 critical care beds – 28 of which provide the highest level of intensive care possible.

There are 11 critical care units spread across five of the region's seven hospital organizations. It is important to remember that each of those units provide differing levels of service. The goal is to look at critical care services as a regional resource, as if each of those units were in one big hospital with different levels of intensive care and patients flowing between the units based on their needs and the ability of the system, not just the site, to provide the best possible care.

Ontario's Critical Care and Trauma Lead Dr. Bernard Lawless (seated, second from left) and South East Critical Care Lead Dr. John Muscadere (back row, second from right) with many of the critical care leaders from across the South East.

Mental Health Services: Consumer Survivor Initiatives (CSI) across the South East were enhanced and stabilized with integration of services across the region. Today, the same 'basket' of services is being made available to clients regardless of where they live.

Frontenac Community Mental Health (CMH) Services has also been involved with an initiative that supports the selection, development and evaluation of a common approach to client assessment in Ontario. Called CHM Community Assessment Program, the purpose of this approach is to assist client-led decision making at an individual level. It identifies each individual's needs and helps match these to existing services. It also identifies gaps in service. Additionally, it facilitates inter-agency communication through common data standards.

In Brockville, five mental health agencies have partnered to improve coordination of care, improving inter-agency communications and efficiency from both a common intake and an administrative perspective. The partner agencies include Leeds-Grenville Counseling & Rehabilitation Services, the Canadian Mental Health Association, Brockville Mental Health (Outpatient & Crisis programs), Assertive Community Treatment Teams, and Consumer Survivor Services & Treatment Orders.

Transportation: Many people have been engaged in the development of a regional transportation strategy. Upper tier municipalities and their emergency services departments, the Ministry, community care access centre, health service providers who operate transportation services, the main receivers of patients throughout the LHIN and agencies who provide transportation services outside of the traditional government or LHIN providers (such as the Canadian Cancer Society) have all been involved.

Actions being undertaken include:

- Deployment of the health vans announced in the summer of 2008 began across the region on a test project basis in the fall of 2008. These vans are used to transport individuals to and from a variety of health services in the region. Based on the experience gained, permanent deployments will be made in 2009/2010;

- Development of two ongoing working groups for planning of service improvement. The first is the non-urgent transportation working group, which provides simple transfers. The second is the emergency transportation provided by paramedics from emergency medical services.

Health Human Resources: In October 2008, a member of the HealthForce Ontario Marketing and Recruitment Agency joined the LHIN office staff, strengthening the relationship between organizations and moving forward with development of a comprehensive Health Human Resources Plan for the region. This plan includes strategies focused on educating, recruiting and retaining health care professionals across the south east. Significant work is also underway to ensure that the skills of our health professionals are being used to their fullest potential.

Community engagement activities: Not only does the LHIN have a mandate to plan and improve integration among health service providers, but it must also engage organizations outside of the health care system and the general public. This mission requires a fundamental shift in the relationship between health care administrators/providers, patients and the public. The South East LHIN has taken bold steps to ensure the mandate of community engagement is fulfilled and that meaningful, inclusive engagement becomes a major driver of health system reform. All health service providers have learned that they need to listen to their patients and the public.

In early 2008, the South East LHIN undertook a unique engagement activity with the goal of producing a compelling vision statement that would drive the design and delivery of health services in the region. In doing so, the LHIN was also able to demonstrate the practicality and power of working directly with citizens to make informed decisions about their health-care system.

It was at a Citizens' Regional Health Assembly in 2008 that participants who were selected at random were engaged in a structured process of learning, consultation, deliberation and recommendation over two days. These four phases allowed participants to gain insight, work collaboratively and reach a broadly-shared agreement on the meaning of engagement. The Regional Health Assembly was the first of its kind in Canada. It revealed the willingness of the LHIN to engage its citizens in a meaningful way and extended a substantial responsibility to the Assembly to develop the principles on which future LHIN initiatives would be founded.

Given that community engagement in health care is a fairly new undertaking, the South East LHIN was one of three LHINs to take part in a project called *Engaging with Impact: Targets and indicators for successful community engagement by Ontario's LHINs*. In November 2008, another randomly-selected group of people were brought together for the Citizens' Workshop on Engagement and Health and were asked to help the LHIN develop a series of targets and indicators to allow it to measure its own performance. The resulting scorecard is currently being used in the province-wide discussion on how to measure the quality and impact of community engagement activities. The final report and a summary video are available at: http://www.massIbp.com/projects_detail.php/ontario_health_public_engagement.html

In January 2009, the LHIN kicked off its ENGAGE 2009 activities that included a two-day Practitioners' Workshop on Health Priorities and Integration Planning in Kingston and a three-day Citizens' Reference Panel in February and March. Both of these activities were designed to engage stakeholders in generating ideas and suggestions for consideration for creation of the next three-year Integrated Health Services Plan. The questions for the practitioners and panel workshops were how can we do things better by doing things differently and working together? How can we unlock the untapped value through integration? The final report and material from the workshop are available at: http://www.southeastlhin.on.ca/Page.aspx?id=2354 .

The ENGAGE 2009 Citizens' Reference Panel involved a civic lottery selection of 36 citizens from across the South East LHIN. Held over the course of three Saturdays, one of the sessions included having the panelists host a public town hall event, broadening participation and the voices added to the health care conversation. The panel provided the LHIN with 15 defined recommendations for consideration. The final report is available at: http://www.southeastlhin.on.ca/Page.aspx?id=2346 .

Collaboration and consultation with its stakeholders is integral to the mission of the South East LHIN. As front-line providers of care, health professionals are essential members of the community and have a valued role in helping achieve the vision of health care in Ontario. The South East LHIN has a Health Professionals' Advisory Committee (HPAC) made up of members from a variety of health services professions. This active multi-disciplinary committee has the important responsibility of providing advice to the LHIN many topics including how to gain the cooperation and involvement of all health-care professionals in supporting change in the local health-care system and developing the leadership role of health professionals in providing integrated healthcare delivery.

French language initiatives

The LHIN has undertaken significant planning in anticipation of the May 1, 2009 official designation of Kingston under the *French Language Services Act*. The South East LHIN facilitated meetings with providers and planners to develop action plans that would provide focus in developing French language health services. Each affected provider identified their current capacity to offer French language health services and set out strategies to be further developed. Each is working towards being a designated French language service provider. To this end, Kingston health service providers are exploring options to share resources so that providers with limited capacity could provide some level of service to the population. By working together, health services are able to pool limited resources and identify strategies that all can employ. Work to further implement action items from the plans will continue throughout 2009/10.

Similarly, the LHIN itself is working towards providing our planning and engagement services in both French and English. When calling the LHIN, people are greeted in both official languages.

Aboriginal relationships

The South East LHIN recognizes the role of First Nations and Aboriginal peoples in the planning and delivery of health services in their communities. We also recognize the concerns expressed by some Aboriginal communities about the potential impacts of health system transformation and devolution to the LHIN system. Our activities focus on improving relationships as a means to creating awareness and trust between the LHIN and Aboriginal communities. This will lead to a strong working relationship.

In October 2008, several Board and staff representatives of the South East LHIN were invited to and attended a successful cultural sensitivity training session with the Mohawks of the Bay of Quinte. The day concluded with expressions of interest for continued relationship-building between the groups. Similar activities are expected with the Katarokwi Native Friendship Centre and with the Métis Nation of Ontario in 2009.

Integration activities

The South East LHIN Board advocates a pro-integration approach to health service provider Board governance. In September 2008, the South East LHIN, along with Central West, Central East, Erie St. Clair and Central LHINs and the Ontario Health Providers Alliance and the Ontario Association of Community Care Access Centres, released the Governance Resource and Toolkit for Voluntary Integration Initiatives. The purpose of the toolkit is to assist health service provider boards to understand evolving LHIN practices, processes and expectations arising from LHSIA. The toolkit helps boards to understand their roles and responsibilities in providing appropriate leadership to their organizations and in developing strategies to work with one another on voluntary integration initiatives. The toolkit is available at http://www.southeastlhin.on.ca/Page.aspx?id=1924 .

In 2008/2009, the South East guided several integration initiatives. All Consumer Survivor Initiatives (CSI) in the LHIN were brought under one governance structure through a facilitated approach. This united CSI presents an opportunity to standardize training and development of the peer initiative while providing a 'basket' of services that is equitable and stabilized for the region. The new regional CSI program is now united as the Mental Health Support Network South Eastern Ontario.

To assist an agency struggling with the accountability commitments, the South East LHIN supported a voluntary integration between the Central Frontenac Community Services and the Independent Living Centre – Kingston. This integration improved efficiency and accountability with no disruption in services to clients. It was a win-win solution for everyone.

The Shared Support Services Southeastern Ontario (3SO) project involving hospitals in the LHIN and the Health Care Network of Southeastern Ontario was formally launched in September 2008. This not-for-profit non-share capital corporation has a goal of creating a single regional supply chain service to generate savings for the hospitals. These savings will be redeployed to improve front-line patient and client care within the region.

LHIN initiatives in support of Government priorities

ER wait times initiatives

Emergency Room (ER) volumes and waiting times are a flashpoint for system failures. There are two key elements that could reduce pressure on ERs: a reduction in the number of ALC patients and a reduction in the demand on ER resources by frequent users and people needed important but non-urgent care.

Initial results from the Emergency Department Reporting System (EDRS) indicated that waiting times at Kingston General Hospital (KGH) and the Belleville site of Quinte Healthcare Corporation (QHC) were substantially greater than those at other hospitals across the LHIN. Innovative programs designed and developed in the South East have been implemented to address system issues with a focus on these sites with the greatest waiting times.

The Eldercare Access Strategy in Emergency Room (EASIER+) was a joint effort of community-based service organizations (CCAC and the community support sectors), administrative and front-line representatives from Kingston and Belleville hospitals, and the LHIN. Geriatric specialists at Providence Care provided expert advice and support. The program was designed to identify frail elderly individuals when they first come to the ER and to provide them with an assessment and an individualized care plan for supports they need to allow them to return home and maintain their independence in the community.

The goals of EASIER+ are to reduce in repeat visits to the ER - our so-call 'frequent flyers' - and with appropriate support in the community, to reduce their need for admission to hospital. The program includes education components for front-line workers and follow-up contact with the patient's family physician alerting them to the patient's ER visits. Some process issues with the program have been identified and are being addressed before EASIER+ expands across the LHIN in the coming year.

Another program aimed at reducing wait times in high-volume ERs is the Ministry of Health and Long-Term Care's Pay4Results (P4R) program. Identified as one of the 23 hospitals in the province with the longest waiting times in their ER, KGH was invited to participate in the program. The goal was simple – to reduce ER waiting times for both high acuity and low acuity patients. Though activities could be targeted beyond the hospital and involve community partners or other hospitals, it was decided that the funding could best be used to address process and capital improvements within the hospital. An overcapacity station was created as were ways to reduce overcrowding of patients in the ER. More than half of KGH's ER was redesigned to improve how patients flowed. At the time these efforts were implemented ER waiting times had become even longer than when KGH was identified for inclusion in the program. The activities have since resulted in significant reductions in ER waiting times. They are expected to contribute to an increased patient satisfaction with how they receive their emergency care.

KGH has identified and embraced a need for change in process and practice patterns across their organization. In a time of substantial and necessary transformation within the hospital, P4R allocations focused on process improvements across departments within the hospital. P4R activities are now part of a broader patient flow discussion in the hospital and in conjunction with regional ALC activities. The potential is there to not only continue improvement within the hospital but expand solutions and improvements across the LHIN.

Improving the Alternate Level of Care (ALC) situation

ALC refers to a patient who has completed the acute phase of their hospitalization but remains in a hospital bed while waiting for care elsewhere. Presently, a high number of acute care hospital beds in the South East are occupied by individuals that have been identified as able to go home with supports or requiring care elsewhere, most often at a long-term care home.

In order to reduce the high number of ALC patients in our hospitals, the South East LHIN is leading a multi-sectoral charge to ensure seniors have their health care needs met in an environment appropriate for their needs. The current reality must be corrected. Patients cannot be allowed to languish in hospital beds where their health may decline, their convalescence extend and their recovery be delayed or prevented. An action-focused, change-oriented health system task group with committed resources from the LHIN, hospitals, CCAC and community agencies and members of the public was established in September 2008. This group is taking an aggressive multi-pronged approach to turn the ALC crisis around. The LHIN views high ALC numbers as a symptom of a broader health system breakdown. The focus is on changing the culture. An ALC designation must be seen as a failure to provide the appropriate care for patients and as a failure of the local health care system.

In addition to the very real human costs for these patients, this situation has a dramatic impact on the system as a whole. Patient flow is impaired. Patients wait in the ER when no beds are open to admit them to. Surgeries are cancelled. Patient transfers between hospitals are slowed down.

Remaining in hospital beyond the length of stay appropriate for the individual's health situation has been shown to have negative impacts on patient outcomes. Additional, unnecessary lengths of stay in hospital are often associated with declining functional abilities, increased dependency and care requirements, exposure to infections and adverse events, depression and premature death.

The South East LHIN is investing a significant amount of human and financial resources to lead efforts to resolve the ever-growing ALC challenge within our hospitals and communities. As part of the ER/ALC Strategy announced by the province in May 2008, the following initiatives are being pursued in the South East:

- ALC Urgent Priority Funding – specific growth funding provided to the LHIN by the MOHLTC to be targeted to activities that directly support ER/ALC Strategy.
- Enhanced integration between hospitals and community.
- Improving flow of patients through the ER.
- Collecting and reporting ER information.

Additionally, implementation of further complementary initiatives was also undertaken:

- Seniors Managing Independent Living Easily (SMILE) – a unique innovative program funded through the Aging at Home initiative which provides services for our most frail seniors who need assistance with instrumental activities of daily living to avoid premature institutionalization or unnecessary hospitalization.
- Flo Collaborative – focusing on redesigning processes and activities within the hospital to improve flow of patients from the "front door" – admission to an in-patient floor - and out the "back door" – discharged from hospital.
- Reactivation programs for frail elderly in hospital to keep them at their best possible level of functional ability while in hospital to ensure that they have the strength, mobility, and independence to return home.
- Building 14 new complex continuing care beds at Lennox & Addington County General Hospital.

eHealth initiatives

A regional eHealth Project Management Office (PMO) was created in October 2008 to manage local implementation of eHealth initiatives, with appropriate reporting to the eHealth program.

Three significant eHealth milestones were achieved in 2008/2009, bringing the South East closer to launching an electronic health record and improving the quality and safety of health care for our residents. In February, representatives from Brockville General Hospital (BGH) and an area community health centre and family health teams from the surrounding communities of Brockville, Portland, Athens and Gananoque undertook a Lean-based Kaizen project to improve their workflow processes, enabling them to work smarter, together. At the same time, two other projects were undertaken involving the implementation of xWave technology to bridge patient care systems between physicians and acute care hospitals in the Kingston and Prince Edward County areas.

As the South East LHIN prepares to roll out the provincial diabetes strategy and e-health program in 2009-10, there will be a focus in the following key areas:

- Review of local roles and processes, in particular discussion of how a primary-care driven chronic disease system impacts on the roles of hospitals, community agencies, CCAC and other providers.
- Further development of appropriate action and advisory committees that include clinicians, IT professionals and administrative managers to appropriately implement the strategy.
- Implementation of pilot sites for the diabetes registry.

Analysis of South East LHIN Operational Performance

Operations Funding

The South East LHIN's operational budget allocation for the 2008/2009 fiscal year was $4,619,185. The LHIN ended the fiscal year in a balanced budget position. While the LHIN's budget was $4.6M, the MOHLTC provided $622,750 in additional funding targeted at specific ancillary-funded projects in support of the LHIN mandate and Ministry priorities. The funds were used to support a variety of initiatives, including eHealth, Aboriginal (Provincial and Federal), emergency department, ER/ALC and the 70%full-time nursing initiative.

Human Resources

The South East LHIN's organizational structure allows for 25 full-time equivalents. During the 2008/2009 fiscal year, the LHIN compliment consisted of 23 full-time equivalents (24 staff).

Board Members' Remuneration

With nine positions available and an average of seven positions filled throughout the fiscal year, the total cost of board member per diems was $149,042 for 2008/2009.

Deloitte

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Auditors' report

To the Members of the Board of Directors of the
South East Local Health Integration Network

We have audited the statement of financial position of the South East Local Health Integration Network (the "LHIN") as at March 31, 2009 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the South East Local Health Integration Network as at March 31, 2009 and the results of its operations, its changes in its net debt and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 1, 2009

Member of
Deloitte Touche Tohmatsu

Statement of financial position

	2009	2008
	$	$
Financial assets		
Cash	1,011,618	1,130,024
Accounts receivable	1,788	38
	1,013,406	1,130,062
Liabilities		
Accounts payable and accrued liabilities	1,016,982	685,804
Due to MOHLTC (Note 3A)	-	438,410
Due to MOHLTC - e-Health (Note 3A)	-	31,529
Due to MOHLTC - Aging at Home (Note 3A)	4,925	10,977
Due to MOHLTC - Emergency Department (Note 3A)	670	7,968
Due to MOHLTC - ER/ALC Initiative (Note 3A)	300	-
Due to the LHIN Shared Services Office (Note 5)	16,697	1,869
Deferred capital contributions (Note 6)	292,545	112,047
	1,332,119	1,288,604
Net debt	(318,713)	(158,542)
Non-financial assets		
Prepaid expenses	26,168	46,495
Capital assets (Note 7)	292,545	112,047
	318,713	158,542
Accumulated surplus	-	-

Approved by the Board:

Georgina Thompson

Georgina Thompson, Board Chair

Leslie Benecki

Leslie Benecki, Director & Audit Committee Chair

Statement of financial activities

	2009		2008
	Budget (unaudited) (Note 8)	Actual	Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Notes 8 & 9)	852,794,483	905,077,193	865,290,124
Operations of LHIN (Notes 8 & 10)	3,788,656	4,384,082	3,869,156
E-Health (Note 4a)	425,000	425,000	275,000
Emergency Department (Note 4b)	75,000	75,000	43,800
Aboriginal Initiative (Note 4c)	15,000	15,000	-
Aboriginal Health Transitions Fund Initiative (Note 4d)	24,450	24,450	-
ER/ALC Initiative (Note 4e)	33,300	33,300	-
70% Full Time Nursing Initiative (Note 4f)	50,000	50,000	-
Aging at Home	-	-	182,000
Other revenues	-	-	831
Amortization of deferred capital contributions (Notes 2 & 6)	-	54,605	58,447
	857,205,889	910,138,630	869,719,358
Expenses			
Transfer payments to HSPs (Notes 8 & 9)	852,794,483	905,077,193	865,290,124
General and administrative (Note 10)	3,788,656	4,438,687	3,928,434
E-Health (Note 4a)	425,000	425,000	268,689
Emergency Department (Note 4b)	75,000	74,330	35,832
Aboriginal Initiative (Note 4c)	15,000	15,000	-
Aboriginal Health Transitions Fund Initiative (Note 4d)	24,450	24,450	-
ER/ALC Initiative (Note 4e)	33,300	33,000	-
70% Full Time Nursing Initiative (Note 4f)	50,000	50,000	-
Aging at Home	-	-	171,023
	857,205,889	910,137,660	869,694,102
Annual surplus before funding repayable to the MOHLTC	-	970	25,256
Funding repayable to the MOHLTC (Note 3A)	-	(970)	(25,256)
Annual surplus and closing accumulated surplus	-	-	-

Statement of changes in net debt

	2009	2008
	$	$
Annual surplus	-	-
Acquisition of capital assets	(235,103)	(4,500)
Amortization of capital assets	54,605	58,447
Change in other prepaid expenses	20,327	14,687
Increase in net debt	(160,171)	68,634
Opening debt	(158,542)	(227,176)
Closing net debt	(318,713)	(158,542)

Statement of cash flows

	2009	2008
	$	$
Operating		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	54,605	58,447
Amortization of deferred capital contribution (Note 6)	(54,605)	(58,447)
Changes in non-cash operating items		
(Increase) decrease in accounts receivable	(1,750)	4,893
Decrease in prepaid expenses	20,327	14,687
Increase in accounts payable and accrued liabilities	331,178	109,133
Decrease in due to MOHLTC	(438,410)	-
(Decrease) Increase in due to MOHLTC - E-Health	(31,529)	6,311
(Decrease) Increase in due to MOHLTC - Aging at Home	(6,052)	10,977
(Decrease) Increase in due to MOHLTC - Emergency Department	(7,298)	7,968
Increase in due to MOHLTC - ER/ALC Initiative	300	-
Increase (decrease) in due to the LHIN Shared Services Office	14,828	(51,372)
	(118,406)	102,597
Investing		
Acquisition of capital assets	(235,103)	(4,500)
Financing		
Increase in deferred capital contributions (Note 6)	235,103	4,500
Net (decrease) increase in cash	(118,406)	102,597
Cash, beginning of year	1,130,024	1,027,427
Cash, end of year	1,011,618	1,130,024

1. Description of business

The South East Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the South East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2009.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN is home to over 482,000 people, which encompasses the areas of Hastings, Prince Edward, Lennox and Addington, Frontenac, Leeds and Grenville Counties, the cities of Kingston, Belleville and Brockville, the towns of Smith Falls and Prescott, and part of Lanark and Northumberland Counties. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets and losses in the book value of assets.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any Ministry managed programs.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at year end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Maintenance and repair costs are recognized as an expense when incurred. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized, on a straight line basis, over their estimated useful lives as follows:

Office equipment	5 years
Computer equipment	3 years
Leasehold improvements	Life of lease
Web development	3 years

For assets acquired and brought into use, during the year, amortization is provided for a full year.

2. Significant accounting policies (continued)

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

A. The amount repayable to the MOHLTC is made up of the following components:

			2009	2008
	Revenue	**Expenses**	**Surplus**	Surplus
	$	**$**	**$**	$
Transfer payments to HSPs	**905,077,193**	**905,077,193**	**-**	-
LHIN operations	**4,438,687**	**4,438,687**	**-**	-
E-Health	**425,000**	**425,000**	**-**	6,311
Emergency department initiative	**75,000**	**74,330**	**670**	7,968
Aboriginal initiative	**15,000**	**15,000**	**-**	-
Aboriginal health transitions Fund initiative	**24,450**	**24,450**	**-**	-
ER/ALC Initiative	**33,300**	**33,000**	**300**	-
70% Full time nursing initiative	**50,000**	**50,000**	**-**	-
	910,138,630	**910,137,660**	**970**	14,279
Aging at Home (relates to prior year)	**-**	**-**	**4,925**	10,977
	910,138,630	**910,137,660**	**5,895**	25,256

B. The amount due to the MOHLTC at March 31 is made up as follows:

	2009	2008
	$	$
Due to MOHLTC, beginning of year	**488,884**	463,628
Funding repaid during the year	**(488,884)**	-
Funding repayable to the MOHLTC	**5,895**	25,256
Due to MOHLTC, end of year	**5,895**	488,884

4. a) **E-Health Initiative**

During fiscal 2009, the South East LHIN received funding in the amount of $425,000 from the MOHLTC. These funds were used toward initiatives in support of its strategic e-Health Plan as defined in its Integrated Health Services Plan.

	$
Expenses	
Salaries and benefits	205,293
Consulting services	187,581
Travel	2,307
Meeting expenses	896
Other	28,923
	425,000

b) **Emergency Department Initiative**

During fiscal 2009, the South East LHIN received funding in the amount of $75,000 from the MOHLTC. These funds were used toward initiatives in support of the strategic Emergency Department Initiative and fell under the Access to Specialized Medical Services, within the Integrated Health Services Plan 'Priority for Change'. Unspent funds, amounting to $670 at year end, are repayable to the MOHLTC.

	$
Expenses	
Salaries and benefits	67,500
Consulting services	3,298
Meeting expenses	53
Other	3,479
	74,330

c) **Aboriginal Initiative**

During fiscal 2009, the South East LHIN received funding in the amount of $15,000 from the MOHLTC. These funds were used toward planning and engagement with the Aboriginal community in support of the Integrated Health Services Plan 'Priority for Change'.

	$
Expenses	
Other	15,000
	15,000

4. (continued)

d) **Aboriginal Health Transitions Fund Initiative**

During fiscal 2009, the South East LHIN received funding from the Federal Government via the MOHLTC in the amount of $24,450 from the MOHLTC. These funds were used to support implementation of the approved project under the Aboriginal Health Transitions Fund Initiative.

	$
Expenses	
Other	24,450
	24,450

e) **ER/ALC Initiative**

During fiscal 2009, the South East LHIN received funding in the amount of $33,300 from the MOHLTC. These funds were used in support of the ER/ALC Strategy. Unspent funds, amounting to $300 at year end, are repayable to the MOHLTC.

	$
Expenses	
Salaries and benefits	29,486
Travel	272
Other	3,242
	33,000

f) **70% Full Time Nursing Initiative**

During fiscal 2009, the South East LHIN received funding in the amount of $50,000 from the MOHLTC. These funds were used in support of the MOHLTC directive on Full time Nurses in Hospitals.

	$
Expenses	
Other	50,000
	50,000

5. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and, as such, is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end is recorded as a receivable from (payable to) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

6. Deferred capital contributions

	2009	2008
	$	$
Balance, beginning of year	**112,047**	165,994
Capital contributions received during the year	**235,103**	4,500
Amortization for the year	**(54,605)**	(58,447)
Balance, end of year	**292,545**	112,047

7. Capital assets

			2009	2008
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office equipment	**273,788**	**36,448**	**237,340**	22,506
Computer equipment	**65,220**	**58,257**	**6,963**	10,634
Leasehold improvements	**116,854**	**70,112**	**46,742**	70,112
Web development	**21,500**	**20,000**	**1,500**	8,795
	477,362	**184,817**	**292,545**	112,047

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget at April 1, 2008. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirement. During the year the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $905,077,193 is made up of the following:

	$
Initial budget	**852,794,483**
Adjustment due to announcements made during the year	**52,282,710**
Total budget	**905,077,193**

The total operating budget of $4,619,185 is made up of the following:

	$
Initial budget	**3,788,656**
Additional funding received during the year	**830,529**
Total budget	**4,619,185**

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $905,077,193 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2008 as follows:

	2009	2008
	$	$
Operation of Hospitals	**605,347,505**	584,042,592
Grants to compensate for Municipal Taxation - Public Hospitals	**188,475**	188,475
Long Term Care Homes	**138,338,261**	129,672,808
Community Care Access Centres	**89,228,091**	84,537,862
Community Support Services	**20,035,925**	16,916,594
Assisted Living Services in Supportive Housing	**1,944,690**	1,901,900
Community Health Centres	**13,512,469**	12,410,360
Community Mental Health Addictions Program	**36,481,777**	35,619,537
	905,077,193	865,290,128

10. General and administrative expenses

The Statement of Financial Activities' expenses are classified by object, as follows:

	2009	2008
	$	$
Program based		
Salaries and benefits	**2,960,329**	2,443,412
Consulting and LHIN-based projects	**226,555**	261,817
	3,186,884	2,705,229
Shared services	**300,000**	300,000
Other (details listed below)	**241,860**	249,287
Occupancy	**163,071**	177,020
Office equipment and supplies	**188,053**	160,509
Board per diem	**149,042**	130,767
Public relations	**99,816**	87,796
Mail, courier and telecommunications	**55,356**	58,548
	4,384,082	3,869,156
Amortization	**54,605**	58,447
Recovery travel	**-**	831
	4,438,687	3,928,434

The breakdown of "Other" general and administrative expenses listed in the table above are:

	$	$
Training and development	**57,811**	67,098
Travel	**160,242**	122,004
Recruitment	**5,330**	42,952
Insurance	**16,281**	16,182
Other miscellaneous	**2,196**	1,051
	241,860	249,287

11. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 22 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2009 was $232,948 (2008 - $201,848) for current service costs and is included as an expense in the Statement of Financial Activities.

12. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

13. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next two years are as follows:

	$
2010	87,553
2011	4,570
	92,123

The LHIN does not have any funding commitments to HSPs associated with accountability agreements.

14. Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently disclosed information of all appropriate segments and, therefore, no additional disclosure is required.

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Local Health Integration
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